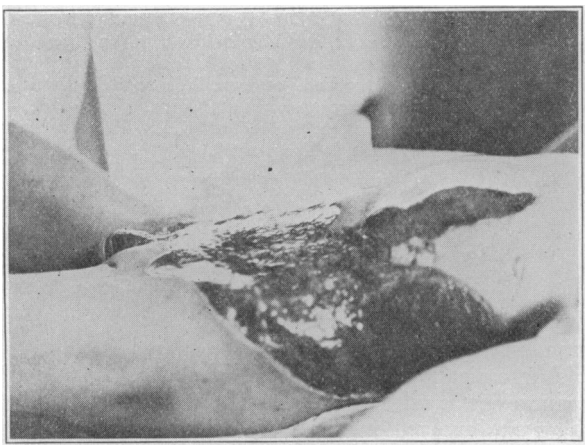


lescence, but after two weeks was out of danger and making a nice recovery. The photographs were taken August 20, and upon August 29 an extensive skin graft was done by Dr. Lavery and myself by the Thiersh method. This has taken well for the most part, and the patient is well on the road to a complete recovery.

This case is of interest because of the extensive injury, of which the pictures give only a small idea, and from the fact that recovery was made after such an injury involving such a tremendous area and severely injuring the testicles, scrotum and penis, and producing severe shock.

CONGENITAL CYSTIC KIDNEY

A CASE REPORT

By WALTER PRITCHARD, M. D., *Colton, California*

J. M. B. Teacher, single, age 40. In October, 1923, complained of cramps in the right loin for five days, with fever, headache, and vomiting.

One sister had a "cystic kidney" excised during her forties; the diagnosis was made after operation. Another sister, now in her fifties, is pale and puffy in the face, but repeated urine examinations fail to confirm the suspicion of nephritis.

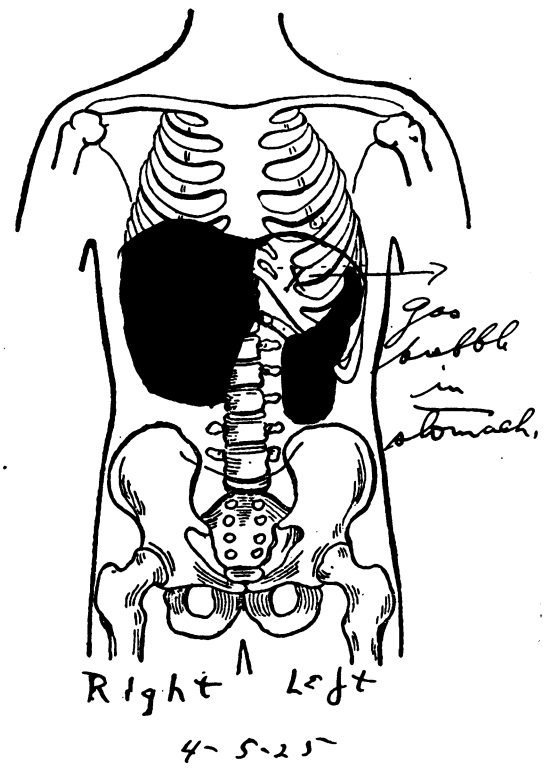
For twenty years the patient had had attacks of colic in the right loin, with belching, bloating, headache, and fever, lasting a few days and occurring a few months apart. Between the attacks he had diffuse headaches. Fifteen years ago he bruised the left loin in a fall. He had "meningitis" twelve years ago. For several years, ending five years ago, he had "pyelitis and nephritis," a systolic blood pressure of 200, and took urotropin daily.

P. E.—The patient was of average weight and development; temperature, 98.4; pulse, regular 80; blood pressure, 140/90. There was marked tenderness in the right loin and less on Murphy maneuver; no psoas spasm; peristalsis was active. There were 16,000 white cells, with 83 per cent polynuclears. The urine was slightly acid, clear amber, 1.018; showed a heavy trace of albumen, trace of indican, a few hyaline-granular casts, and a moderate number of red, white, and renal cells. A tentative diagnosis was made of right pyelitis and nephritis, probably an exacerbation. With rest, local hyperemia, forced fluid intake, and urotropin gr. 15 q. 4 hr., the patient became comfortable within a few days. He refused cystoscopy.

During the next year and a half the patient was seen in several attacks, and the investigations made are here summarized. He finally consented to cystoscopy, which yielded a conclusive diagnosis. Because of the fragmentary development of these investigations, chronological treatment seems better replaced with topical consideration.

Symptomatology—Pain in the loin had harassed the patient for twenty years. It had been in the right side until the past year, and then worse in the left loin. In character it suggested "a lighted candle burning in my side all the time," with cramps during the height of the attack. The pain did not radiate, and was not influenced by voiding or defecating. Nausea and vomiting, malaise and diffuse frontal headache were frequent. There was frequently a chill and febrile rise to 102, and rapid drop within a few hours. The attacks occurred at any time, beginning rapidly and lasting for hours or days, and were of varying severity. The intervals decreased from months to weeks, and even days. Gross hematuria was never seen. Nicturia once was habitual, but large amounts of urine were never passed.

Subsequent physical examinations revealed constant tenderness in both flanks, becoming exquisite during attacks. A mass was first noticed in March 27, 1925, continuous with the liver to percussion and palpation; it was firm, smooth, slightly tender, reaching downward in the right half of the abdomen to the level of the umbilicus. The sharp lower edge moved with respiration, and was continued in a rounded, firm superficial mass at the right rectus border, suggesting a distended gall-bladder, and measuring two inches across. This mass can be seen in the x-ray of April 5, 1925. A month later the topography had changed: a firm, smooth, tender mass three inches in diameter lay in the midright lower quadrant and moved with respiration, but could not be displaced. The liver edge could be felt just under the ribs. Immediately after cystoscopy, and with the bladder drained, the patient voided two quarts of urine, and this mass moved four inches cephalad.



No. 1

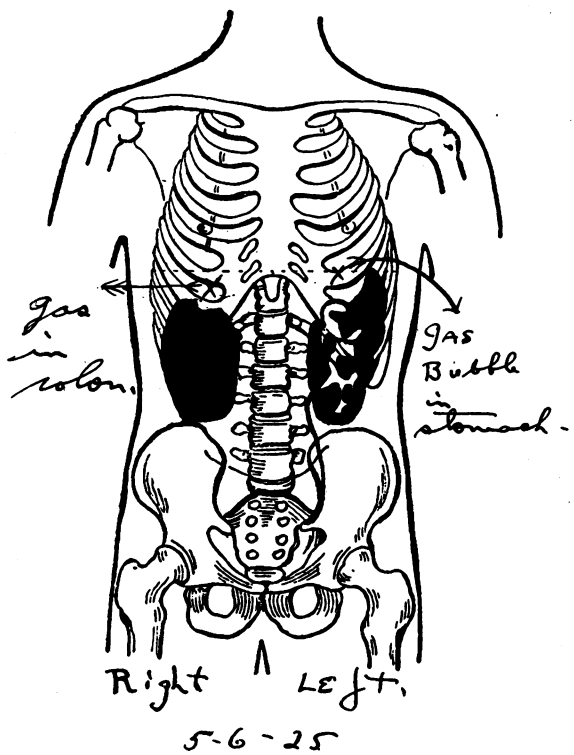
The x-ray of April 5, 1925, shows the left kidney shadow with a faintly scalloped external border, and upper pole covered by gas in the stomach. The right upper abdomen is occupied by a shadow of uniform density extending from the diaphragm to the level of the umbilicus, and from the midline to the lateral abdominal wall.

Cystoscopies—One on April 5, 1925, indicated a normal bladder, except for slightly enlarged median prostatic lobe. Normal ureteral ostia emitted turbid urine at an average rate. A No. 6 catheter easily passed to the left pelvis, but would not drain, although readily admitting water. The left pelvis admitted 12 cc. of 20 per cent sodium iodide solution, with pain characteristic of the attacks. The right ureter readily admitted a No. 5 catheter, and drained urine at an average rate. It was not thought wise to inject both kidneys at the first sitting.

On May 6, 1925, both ureters were emitting turbid urine; catheter to left pelvis, but stopped at pelvic brim in the right side. Both dropped urine rapidly. The left

side admitted 35 cc. of injection fluid readily, with pyelogram as shown. The right catheter, unfortunately, slipped out in removing the cystoscope. But the shadow of the right kidney was so plain that further examinations did not seem necessary. After intramuscular injection, phthalein appeared in twelve minutes from the right side, and in nineteen minutes from the left side.

X-rays — The pyelogram of April 5, 1925, shows the left pelvis only partly distended, with those calices shown, blunted. The pelvis is six inches long, and the kidney shadow about nine inches long by four and a half inches wide, and extends from the dome of the diaphragm to within an inch of the iliac crest. The "liver" shadow is shown, extending downward with uniform density to a sharp lower border at the level of the umbilicus. The gall-bladder region was normal in especially taken x-rays. The x-rays of May 6, 1925, show the left pelvis better distended, and the same blunted calices. The outline of the right kidney is clearly shown in the corresponding position and size, only an inch lower, reaching the iliac crest. This shadow is felt to be the right kidney because it corresponds in size and shape and position with the known left kidney; because the mass markedly shrank and moved cephalad after copious voiding; because of the varying position of the mass in the right side of the abdomen; and because a sister had a cystic kidney removed.



No. 2

The x-ray of May 6, 1925, shows the left kidney as before and with the large, imperfectly filled pelvis and calices. The right kidney occupies the corresponding position. Both are deformed above by gas in the stomach and colon.

Laboratory Data—A twenty-four-hour urine specimen was 2500 cc.; neutral; 1.010; and contained 2 per cent of albumen. On other occasions there were a few pus cells, hyaline and granular casts, and a few red and renal cells. Non-protein nitrogen 34 milligrams for 100 cc. blood. Wassermann test of the blood was negative. A complete blood examination showed nothing abnormal.

Diagnosis—Bilateral congenital systic degeneration of the kidneys.

Treatment—The patient was placed on a cardio-renal regime, and given a ptosis corset with kidney pads. It was hoped thereby to prevent kinking or rotation of the pedicles. His fluid intake was to be over 3000 cc. daily, and the urine to be kept acid six days a week; and urotropin gr. 5 taken bid. During three months, he has been free of pain, fever, or headache, and has gained fifteen pounds. Operation was discouraged because both sides were equally involved, and neither side badly infected. The bizarre masses, without typical signs of hydronephrosis (except once), were confusing. The familial character of the disease is illustrated.

TREATMENT OF OTITIS-MEDIA

By B. C. DAVIES, M. D., *Los Angeles*

In the treatment of this particular condition, both the anatomy and the nature of tissue involved demand special consideration.

Anatomically, we have a semi-closed cavity which communicates with at least two other cavities, while the part involved is relatively minute in area and difficult to reach.

The mucous membrane lining is sensitive and affords a fertile field for infection; moreover, it quickly reacts to irritants, or stimulants, and is capable of producing granulation tissue very rapidly. These findings render treatment difficult and uncertain of results under regulation procedure.

Boric-alcohol instillation goes very little farther than the opening through the tympanum, while the resultant deposit of boric acid impedes both drainage and continued treatment. Phenol-glycerine is no more satisfactory, except in early open cases.

Irrigations, of whatever nature, which contain water do not entirely pass the tympanum, but instead stimulate granulations, which eventually close the tympanic perforation and a chronic otitis-media is established, succeeded frequently by a mastoiditis.

Gentian violet, mercurochrome, acriflavine, and the rest of the newer antiseptics act well on bacteria that are reached, but their progress into the middle ear is easily impeded.

Following its successful use in other purulent conditions, I have for the last year been using pure ether in the treatment of acute and chronic otitis-media, with unvarying success, in over 125 cases. A few case histories follow:

1. Jenny C., age 8. Admitted March 13, 1924. Diagnosis, diphtheria. Acute mastoiditis, left. No operation. Both ears discharging. Boric irrigations. Phenol-glycerine. Treatment lasted five weeks, no improvement. Ether treatment started April 16, 1924. Ears dry, April 30, 1924.

2. John C., age 17. Diagnosis, measles. Ears discharging two weeks before admittance. Had been irrigated since discharge began. Ether treatment started February 13, 1924. Ears dry, February 18, 1924.

3. Mrs. W. J. E., age 47. Post-scarlet otitis-media, left. Ear had been discharging for week. Dry swab, followed by mercurochrome; no results. Ether treatment started March 25, 1924. Ear became dry April 3, 1924. Several cases practically similar cleaned up in one week.

4. James McC., age 7. Scarlet fever, otitis-media, left. Discharge began April 12, 1924. Ether treatment started same day. Dry ear April 20, 1924. Approximately fifteen cases of similar histories showed equally quick results.

5. V. W. M., age 5. Diagnosis, scarlet fever. Ears discharging three days before entry, April 7, 1924. Simple mastoidectomy, right, April 8, 1924. Wound and middle ear washed with ether at time of operation. Canal dry and wound clean, April 15, 1924. Wound healed in less than three weeks. Several cases of the same kind had been irrigated for weeks. Others had been treated with various dye solutions without success.

The technique followed was a careful swabbing, using small cotton swabs, made up fluffed on the